

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/14/2013	
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the PSR (Post Survey Revisit) to the Investigation of Complaints IN00120799, IN00120868 and IN00121015 completed on December 21, 2012.</p> <p>Complaint: IN00120799 - Corrected</p> <p>Complaint: IN00120868 - Corrected</p> <p>Complaint: IN00121015 - Corrected</p> <p>Unrelated deficiencies cited - corrected.</p> <p>Survey dates: February 13 & 14, 2013</p> <p>Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF: 10 SNF/NF: 86 Total: 96</p> <p>Census Payor Type: Medicare: 19 Medicaid: 71 Other: 6 Total: 96</p> <p>Sample: 10</p> <p>Harcourt Terrace Nursing and Rehabilitation was</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 found to be in compliance with 42 CFR part 483, Subpart B, and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaints IN00120799, IN00120868 and IN00121015. Quality Review completed by Tammy Alley RN, on February 18, 2013.	{F 000}			